VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Name
5. Date of Birth (mo/day/year)	6. City/County of Residence		9. Provider I.D. #
7. Race: 1. White 2. Black 3 American Indian 4. Asian 5. Hispanic 6. Other [ ]			10. Provider Name & Address
8. Medicaid I.D. # Previous # (if applicable)			

11. Enter the infant's birth weight and Apgar scores:

A. Birth weight: lbs. _____ oz. _____ B. Apgar: 1 min. _____ 5 min. _____

12. Enter reason infant is no longer receiving Care Coordination Services: [ ] Date closed: _____

1 - Reached age two
2 - Dropped out of well-child care
3 - Transfer to other MICC agency
4 - Lost to follow-up
5 - Eligibility cancelled
6 - Problem resolved
7 - Died
8 - Moved
9 - Other

Instructions: Complete items 13 & 14 only if answer to item 12 is "Died"

13. Enter the infant's age at death (months and weeks) months _____ weeks _____

14. Enter primary cause of infant's death: [ ]

1 - Accident 2 - Congenital abnormality 3 - Birth trauma 4 - Non-congenital illness

Instructions: Complete items 15 through 17 if answer to item 12 is "Died" or "Reached Age Two"

15. Enter total number of prenatal visits by mother during this pregnancy: [ ]

16. Enter number of weeks of gestation when mother began care: [ ]

17. Indicate if mother received Care Coordination Services during this pregnancy: [ ]

1 - Yes 2 - No

Instructions: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two"

18. Enter child's health status at age two: [ ]

1 – Normal health & development
2 – Developmentally delayed
3 – Congenital abnormality
4 – Non-congenital disease

19. Enter child's living situation at age two: [ ]

1 – With parent/guardian 2 – Foster care placement 3 – Long term care facility

20. Enter total number of EPSDT visits during first two years: [ ]

21. Indicate if child is receiving WIC benefits 1 - Yes 2 - No [ ]

22. Enter child's height and weight at age two:

Height: ft. _____ in. _____ Weight: lbs. _____ oz. _____

23. Client Needs

Instructions: Indicate needs that were met through Care Coordinator assistance by entering **"Y" (Yes)** in the appropriate block(s). Indicate clients needs that were not met at the completion of Care Coordination Services by entering **"N" (No)** in the appropriate block(s):

[ ] 1. Child Care [ ] 2. Food Stamps [ ] 3. Housing [ ] 4. Nutrition Counseling [ ] 5. Parenting Education [ ] 6. Home Health Services [ ] 7. Employment [ ] 8. Counseling [ ] 9. School Enrollment [ ] 10. Job Training [ ] 11. Transportation

_____ _____
Coordinator's Signature Date